Tamaris Healthcare (England) Limited

Victoria Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The last inspection of this home was carried out in October 2015. At that time the provider was failing to meet a legal requirement about medicines recording and induction of agency staff. The provider sent us an action plan showing how they would address these matters. During this inspection we found the provider had made improvements in these areas. Medicines records were completed and agency staff were provided with induction so they were aware of safe working practices within the home.

This inspection was carried out on 26 October and 1 November 2016. The first day of the inspection was unannounced.

Victoria Lodge Care Home is registered to provide accommodation and nursing or personal care for up to 46 people. It is a purpose-built care home with two units. The ground floor unit provides care for younger adults who are physically disabled and the first floor provides care for frail older people, some of whom may be living with dementia. At the time of this visit there were 11 people living on the ground floor unit and 25 people accommodated on the first floor.

The home had a registered manager who had been in post for a year. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During this inspection we found some gaps in some people's care records that could lead to inconsistent care. We also found that bathrooms were not in a good state of repair and were cluttered. The provider had a quality assurance system but this had not always identified or addressed the shortfalls found during this inspection.

You can see what action we told the provider to take at the back of the full version of the report.

People said they felt safe and comfortable at the home. Relatives told us it was a safe place for their family members. One relative told us, "I'm sure it is safe. I checked several homes before this one and I know my [family member] is safe here." Staff had regular training in safeguarding adults and understood their responsibilities to protect the people who lived there.

There were enough staff on duty to support the people who lived there. The staffing levels and skill mix throughout the day and night was suitable to meet people's needs. The provider carried out checks to make sure only suitable staff were employed.

People and relatives we spoke with felt staff had the right skills to care for people. Staff told us they had good training opportunities.

People's right to make their own decisions was respected and their consent was sought before care was provided. Staff understood the Mental Capacity Act 2005 for people who lacked capacity to make a decision.

People were supported to eat and drink enough to meet their nutrition and hydration needs. Any changes in people's health were referred to the relevant health care agencies.

The people we spoke with who were able to express a view told us they liked the staff and had good relationships with them. One person commented, "The staff are really nice. They are very cheerful and chatty."

People and staff enjoyed friendly, appropriate interactions. Although staff were busy they stopped to have chats with people and with visitors as they passed by.

Relatives felt staff were caring and patient. One relative told us, "Staff work very hard and are always busy, but they are always cheerful and friendly. I've never heard a wrong word from any of them when they're helping people."

The home employed an activity staff member who was enthusiastic and motivated. People told us they enjoyed various activities arranged by the activities staff member. One person told us, "There's plenty to do. [Name of activity staff] always has something going on for us." There were opportunities for people to go out shopping and to weekly pub lunches.

There was information in the home for people and visitors about how to make a complaint. People said they would feel able to raise concerns if necessary.

People told us they were kept informed about changes in the home and were encouraged to give their suggestions and comments. People and visitors were asked to complete individual questionnaires and also to join regular meetings which gave people a chance to give suggestions as a group. One relative commented, "We have residents/relatives meetings with the manager. She asks what we think and listens to what we say."

The staff we spoke with felt the registered manager was approachable and supportive. One care worker told us, "I think the home is well-managed." Another staff member commented, "We have staff meetings and can say if we think something could be improved."

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Bathrooms were in a poor state and were cluttered with equipment.

There were sufficient staff to meet people's needs. The home only employed staff who had been vetted to make sure they were suitable.

People felt safe and staff knew how to report any concerns about the safety of people who lived there.

Is the service effective?

Good

The service was effective.

Staff had access to training in care and health and safety.

The service applied Deprivation of Liberty Safeguards (DoLS), where applicable, to make sure people were not restricted unnecessarily unless it was in their best interests.

People were supported with nutrition and health care needs.

Is the service caring?

Good

The service was caring.

People and relatives felt staff were caring and friendly.

People were encouraged to make their own choices and these were respected.

People were supported in a way that upheld their dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records were not always up to date or detailed enough to make sure people got consistent support.

There were in-house activities, social events and some opportunities to go out into the local community.

People and their relatives said they had information about how make a complaint and would do this if necessary.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider used several quality assurance tools but these were not always effective in identifying or addressing shortfalls.

There was a registered manager in place and staff felt supported by the management arrangements.

People and relatives were asked for their views of the service.

Victoria Lodge Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 26 October and 1 November 2016. The first day of the inspection was unannounced so the provider and staff did not know we were coming. The inspection was carried out by an adult social care inspector.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. The provider also completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

We contacted the local authority commissioning and safeguarding officers and the clinical commissioning group (CCG). We contacted the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with 10 people living at the service, seven relatives and a visitor. We spoke with the registered manager, the deputy manager, a nurse, a senior care staff and two care workers, a catering staff and an activity co-ordinator.

We reviewed five people's care records and 15 people's medicines records. We viewed three staff files for recruitment as well as supervision and training records for all staff members. We looked at other records relating to the management of the service. We looked around the building and spent time with people and visitors in the communal areas.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we noted that bathrooms were in need of redecoration and one bathroom had a broken lock. At that time we were told that bathrooms were to be redecorated and these issues would be addressed. During this inspection we found that bathrooms had been repainted but there were still damaged wall coverings to two shower rooms and the lock to the bathroom door was still broken. We also noted that the flooring in one shower room had started to split and lift so was a tripping hazard and would also be difficult to keep hygienically clean. Another shower room had a poor odour. Two bathrooms on the first floor were being used to store chairs, laundry trolley and an unused medicine trolley which could also present a tripping hazard if people mistakenly entered these rooms. The door to a sluice room had been left unlocked on first day of the inspection so we asked the staff to lock it as it was a hazardous area for people. On the second day of inspection it was unlocked again, which indicated it was common practice.

The above matters were a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other areas of the home were warm, comfortable and well decorated. A previously unused lounge on the ground floor had been turned into a pleasant 'family room' with a play area for visiting children. People and relatives told us this room was now well-used for family visits and social events.

At the last inspection in October 2015 we found people's medicines were not always being managed in a safe way. This was because there were gaps in medicine administration records so it could not be determined whether people had received their medicines or not. Also people's photographic identification was not always in the medicines records and the home was using several agency nurses at that time who would not be able to identify the right people.

During this inspection we found improvements had been made. We looked at the medicines administration records (MARs) for people using the service. The MARs had been completed and signed by appropriately trained staff when medicines had been offered and administered. In most cases there were photographs attached to these records so staff could identify the person before they administered their medicines. (The photographs of the most recent people to have moved to the home were awaited.)

Nurses and senior care workers or CHAPs were responsible for administering medicines for people who needed support with this. They had received training in medicines management and their competence was checked annually. Medicines were safely stored in specific treatment rooms on each floor. There was a daily record of the ambient temperature of both treatment rooms to make sure the medicines were stored at an appropriate temperature. We did note there had been some days in October 2016 where the temperature had not been recorded. The ambient temperature in both rooms on all other days had been consistently within suitable temperatures for the safe storage of medicines.

At the last inspection in October 2015 we found several agency nurses were being used to cover vacant posts but there were not always records of the induction they had received before they started to work at the

home. This meant the provider could not be certain that the agency staff were familiar with safe working practices within Victoria Lodge, such as fire procedures.

During this inspection we found improvements had been made. At this time there was a vacant post for a registered nurse and another nurse was waiting for their registration as a nurse to be confirmed. In the meantime, the provider was using the same two relief nurses (from the provider's own staff agency) to cover these posts. This meant there was continuity of nursing care and both relief nurses had received induction.

People told us they felt safe at the home. For example, one person commented, "I've been here a while and the staff are always nice." One relative told us, "I'm sure it is safe. I checked several homes before this one and I know my [family member] is safe here." Another visitor commented, "Oh, I know my [family member] is safe here. My [family member] has lived here for a few years and regards it as 'home'."

Staff told us, and records confirmed, they had training in safeguarding people. They were able to describe the reporting systems for concerns about people's safety. Staff had access to a range of policies and procedures, including safeguarding and whistleblowing policies. Staff told us they felt confident about raising any concerns and felt these would be dealt with appropriately. One care staff member told us, "Everything we do in this home is to keep people safe. We all do the safeguarding training and I would feel able to report any issues." Commissioners told us they had no current concerns about the service.

There were risk assessments in place for each person, where appropriate, based on their assessment of needs. This meant risks had been identified and were being minimised to keep people safe. For example, these included risk assessments about the likelihood of pressure ulcers developing or to ensure people were eating and drinking enough. The risk assessments were reviewed each month. The provider also had a computer-based reporting system in place to analyse incident and accident reports in the home. This was to make sure any risks or trends, such as falls, were identified and managed.

There was a 'grab file' for any staff member to use in the event of an emergency in the home. The grab file included details of what to do and who to contact in the event of a flood, fire or staff absence. It also included the personal evacuation plans (PEEPs) for each person who lived there.

We looked at whether there were sufficient staff to care for people in a safe way. People, visitors and staff told us that staffing levels and staff continuity was now improving after a period of change. All the people and visitors we spoke with said there had been a recent turnover of staff and they felt this had led to a reduced number of staff on duty on some days. However all the people we spoke with felt this had improved with the recruitment of new staff. One relative said, "There were a couple of days when there didn't seem to be many staff on so they had breakfast very late, but otherwise it's been ok. They've taken on new ones and one staff came back to work here so it must be an ok place to work."

At the time of this inspection there were 36 people living at the home. There was a nurse, a senior worker and six care workers on duty in the morning. This reduced by one care worker in the afternoon. Overnight there was a nurse and four care workers on duty. The provider used a staffing tool, called CHESS, to determine the staffing levels. The tool used the dependency levels of each person (for example, if they had mobility needs or were cared for in bed) to calculate the number of care and nursing hours required throughout the day and night. The staffing tool indicated that the staffing levels provided at Victoria Lodge would be due to increase by one care worker as three new people had moved into the home over the past week.

The care staff we spoke with told us staffing levels were safe and that there were enough staff on duty to

support people. A nurse felt that "in an ideal world there would be a nurse on each floor" but said there was a care homes assistant practitioner (CHAP) instead to support them with minor nursing tasks.

We looked at the recruitment records of three new members of staff. We found that recruitment practices were thorough and included applications, interviews and references from previous employers. The provider also checked with the disclosure and barring service (DBS) whether applicants had a criminal record or were barred from working with vulnerable people.

The provider carried out monthly checks to make sure that nursing staff were registered with the Nursing and Midwifery Council (NMC). This helped to make sure people received care and treatment from nursing staff who met national standards and abided by the professional code of conduct. This meant people were protected because the home had checks in place to make sure staff were suitable to work with vulnerable people.

Good

Is the service effective?

Our findings

Some people and relatives told us the staff were capable in the roles. For instance, one relative commented, "The staff know exactly how to look after my family member. There are some new staff and some are young but they have to start somewhere and they are all very willing and nice."

Records confirmed staff had opportunities to complete necessary training in care. Most care staff had achieved a national care qualification (called NVQ level 2) in health and social care. Staff also received necessary training in health and safety matters, such as moving and handling, safeguarding, medicines, mental capacity and deprivation of liberty safeguards.

The provider used a computer-based training system for each staff member to complete annual training courses, called e-learning. Staff felt they received sufficient training to support people. For example one care worker told us, "We get lots of training. I've just done dementia awareness. There's more training I would like to do and I think [registered manager] is happy for us to do any suitable courses."

We spoke with the registered manager about the supervision and appraisal of staff members. The service aimed for staff to have six supervision sessions each year and an annual appraisal. The supervision records and planner showed staff had attended around three supervision sessions this year and the registered manager was beginning to carry out annual appraisals. In this way the home was on target to achieve the provider's target. Staff told us they felt supported by the senior and management team.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw the staff had made DoLS applications to the local authority over the past year in respect of 10 people who needed supervision and support at all times, and further applications continued to be made where appropriate.

Most people who lived here were able to make their own choices and decisions. We heard staff asking people for permission before they supported them, for example with personal care, at mealtimes or with medicines. In care records we saw assessments of people's capacity, where appropriate, and best interest decisions about any restrictions, for example about the use of a wheelchair lap strap for their safety.

We looked at how people were supported with their nutritional health. Some people said the quality of the meals had been mixed during a period of change of catering staff. For the past few months there had been vacant catering posts so there had been a number of relief cooks working at the home. One person told us, "It varies depending which cook is on, but its ok." Another person told us, "It was lovely today, and they always give you a choice." One relative commented, "It must be ok because my [family member] is putting on weight."

Dietary requirement sheets were included in people's care records and catering staff showed us they had copies of these so could prepare special diets for people where required. For example some people had pureed meals and thickened drinks because they had difficulty in swallowing. Nutritional risk assessments were completed on a monthly basis and weights were recorded either weekly or monthly depending on people's individual nutritional risk. Nutritional care plans were in place and dieticians had been involved where necessary.

Overall, people we spoke with and relatives felt the people were supported to access health services when needed. One relative told us, "The staff acted quickly to get the GP involved when my family member was acting out of character one day and it turned out to be a water infection." People's care records showed when other health professionals visited people, such as dentist, optician, and dietitian.

Good

Is the service caring?

Our findings

The people we spoke with who were able to express a view told us they liked the staff and had good relationships with them. One person commented, "I love it here. Everyone is so friendly. Staff are good fun and you can have a laugh with them." Another person commented, "The staff are really nice. They are very cheerful and chatty."

We saw there was good engagement and a shared sense of humour between people and the staff. There were several occasions when people instigated jokes and gentle fun-poking at the staff and they all enjoyed these friendly, appropriate interactions. Although staff were busy they stopped to have chats with people and with visitors as they passed by.

Relatives felt staff were caring and patient. One relative told us, "Staff work very hard and are always busy, but they are always cheerful and friendly. I've never heard a wrong word from any of them when they're helping people." Another relative commented, "They are all very caring and they do their best for my [family member]."

One visitor described how their relative had previously lived at the home and they continued to visit some of the people who still lived there. The visitor told us, "Staff were always lovely with my [family member] and I always recommend it to other people. All the staff are very nice."

Relatives felt involved in the care of their family members. One relative described how they visited every day and joined their family member for meals.

Relatives told us the staff aimed to make people comfortable. For example, one visitor told us, "The staff always make sure they put my family member in a comfy chair when they are in their bedroom so they're not sitting in a wheelchair all day." A visitor said, "I took my [family member] out once but they said they wanted to go 'home'. They meant Victoria Lodge so they must think it's ok."

People told us they made their own choices. People chose to spend time in different parts of the home, for example either in the lounges or in the privacy of their own room. People were encouraged to make their own decisions about day to day matters, such as menus, clothing and how and where to spend their day.

We saw people's independence was supported where appropriate and within a risk-taking agreement with people. For example, one person chose to keep their bedroom door locked at night and this was respected by staff. The person also went out independently and told us this was an important part of their lifestyle. People's care records identified whether they could make complex decisions, or where they needed support from other people, including advocates.

People said they were treated with dignity and respect. A staff member told us, "We always make sure of people's privacy, for instance we always close doors when helping people in bedrooms and bathrooms."

One staff member told us, "I think the colleagues I work with are caring to do this job. I never worry about the care that people are getting because I think it's a good service." Another staff commented, "We do our very best for people – that's why we came to work in care."

Requires Improvement

Is the service responsive?

Our findings

We looked at the care records for five people. Care plans identified people's needs such mobility, nutrition and personal hygiene. It was the provider's expectation that care plans were reviewed at least monthly or more often if people's needs were changing.

We looked at the care files for five people. In four of the five files we found inconsistent or out of date guidance for staff in how to support people. Some people's needs had changed since their care plan was designed but the plan had not been updated. This could lead to inappropriate care of those people. For example, one person's care plan, dated July 2015, stated they were at low risk of falls. However since then the person had experienced several falls resulting in a number of injuries and sensor alarms were being used to monitor this. None of this information was apparent within their care plan.

In some of the care records we viewed there was no clear guidance for supporting individual people with 'as and when required' (PRN) medicines. For example one person was prescribed 'as and when required' medicines for agitation. There was no guidance in place to assist care staff in their decision making about when it would be used. There were no descriptors for the level of anxiety and agitation and no information on strategies to try before giving the medicine. This meant different staff may support this person in an inconsistent way.

Another person's moving and assisting plan, written in 2015, stated they needed the support of one care staff with their mobility. However monthly evaluation records showed that the person now required two care staff so this was contradictory. Another person's nutrition care plan stated they could drink normal fluids, but another part of the care records stated the person required drinks to be thickened.

In this way people may receive inconsistent or inappropriate care. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives felt that although there had been some changes to staff there was a consistent group of care staff who knew people's individual needs. One relative commented, "It's good that there's a stable team of staff in amongst all the changes so people are familiar with their faces and they can teach the new ones about people." Another relative told us, "It seems to be the same staff whenever we visit so they're familiar with what my [family member] needs." The staff we spoke with were knowledgeable about people's individual preferences as well as their needs.

The home had two distinct units, one for younger people with physical disabilities on the ground floor and one for older people on the first floor. The people on the ground floor said they tended to go out or spend time in their own rooms.

The home employed an activity staff member who was enthusiastic and motivated. The people on the first floor told us they enjoyed various activities arranged by the activities staff member. One person told us, "There's plenty to do. [Activity staff member] always has something going on for us." A visitor described how

when their family member had lived at the home they got the person "interested in doing things again". In a recent questionnaire one relative wrote, 'The care staff always try to keep my [family member] occupied because they can become very low in mood at times and staff are always doing something to keep my [family member] calm'.

Recent activities described by people included parachute games, exercising music, pamper days, pet therapy (including visits by a miniature pony), reminiscence discussions and 'knit and natter' club. People from both units were invited to join the weekly lunch out to a local pub and shopping trips. People from the first floor also enjoyed spending some time in the ground floor dining room where they could socialise with people from the ground floor unit.

People and their relatives said they would feel able to raise any concerns if necessary. There were posters in the reception area about how to make comments, complaints or compliments. The provider had a clear complaint procedure that included stages and timescales for acknowledging and investigating complaints.

There had been three complaints recorded since the last inspection, two of which had been addressed and one was on-going. Complaints were recorded on the provider's datix (management reporting tool) so the provider could analyse complaints for any trends and make sure that outcomes or actions were completed.

Requires Improvement

Is the service well-led?

Our findings

The provider had a quality assurance programme which included several daily, weekly and monthly audits of the service. These included checks of care records, premises and medicines management. Many of the checks were recorded on quality audit tools that involved staff inputting the information onto an iPad. The computer-based system then analysed the results and identified any actions for improvement.

However we found that the audits had not always been effective as they had not identified or addressed the shortfalls that we found during this inspection. For example, premises checks had not identified the poor state of bathrooms. Also some people's care records had been written in July 2015 but their care needs had changed since then without this being picked up during care plan audits.

Records about checks of the ambient temperature of a medicines storage room had not been completed on several days in the previous month, which was contrary to good practice and to the provider's own protocols. This gap had not been identified within the recent medicines audits.

The registered manager or a nurse carried out a 'daily walkaround' which included a visual check around of the home. For instance, whether communal bathrooms were free from 'clutter'. The daily audit score was invariably 100% which did not match with our findings. The registered manager explained that any issues observed during the 'daily walkaround' were addressed at the time so were scored as if complete. However this did not lead to a record of the remedial action required or of any lessons learned towards future improvement.

This meant the provider's quality assurance system was not effective in identifying or addressing shortfalls in the quality of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, relatives and other visitors told us the atmosphere in the home was "friendly" and "cheerful". They told us they had various opportunities to give their views and suggestions about the service, including a 'quality of life' on-line questionnaire. This meant people, relatives and care professionals or other visitors could leave their views about the home at any time on an easy-to-use iPad computer that was sited in the entrance hallway. People were also encouraged to use an iPad that was brought to them so they could input their comments at any time. Any significant comments were emailed immediately to the registered manager.

We saw people's views were positive. We looked at the analysis of people's feedback over the past three months. All of the people who had taken part said they felt safe, they felt they were treated as an individual and all felt they were treated with respect by the staff. A small number of relatives had also completed the questionnaire on the computer. All their responses were also favourable and all felt their family members were given choices, were well cared for and there were sufficient activities. Relative's comments included, 'I know if I need to speak to someone about my family member there is always someone there to talk to' and 'I am very happy with everything that is done for my family member in Victoria Lodge'.

People and visitors told us resident/relatives' meetings were also occasionally held which gave people a chance to give suggestions as a group. One relative commented, "We have residents/relatives meetings with the manager. She asks what we think and listens to what we say." At the last meeting in October 2016 people, relatives and staff had discussed new staff appointments, forthcoming activities and social events, and questions and suggestions from people. People and relatives said they were kept up to date. For example, the registered manager had explained to them that new cooks had been appointed and were due to commence in post within the next week. People were fully aware of this and felt informed about the changes.

The home was subject to quality monitoring processes by external agencies. For example, at a recent audit of the home by local authority and health commissioning officers, the service scored 72%. Commissioning officers told us the service had improved since the last audit was carried out in 2015.

The staff we spoke with felt the registered manager was approachable and supportive. One care worker told us, "I think the home is well-managed. [Registered manager] has been supportive and sorted out any issues I've raised." Another staff member commented, "I could go to [registered manager] if I needed to discuss anything and I think she's a good manager. We have staff meetings and can say if we think something could be improved."

Staff felt that they received sufficient information about the organisational expectations and standards at staff meetings and individual supervision sessions. Staff meetings were held with clinical staff, care staff, catering staff and health and safety group. A night care worker described how staff meetings were held in the evenings so that day and night staff could at join in the meetings together. Staff said they felt able to contribute their comments at the meetings. This meant staff had the chance to contribute to the running of the home, together with communicating key information to staff to ensure standards of care were maintained or improved.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not protected from the risk of inconsistent care because some care records had not always been updated when people's needs had changed. Regulation 9(3)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People were not always protected against the risks associated with the poor state of repair of bathrooms and the equipment being stored there. Regulation 15(1)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality assurance system was not effective in identifying or addressing shortfalls in the service. Regulation 17(2)(b)